Effective Strategies for Conducting and Monitoring Eligibility Determination

HRSA HIV/AIDS Bureau All Grantee Meeting
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Presentation Agenda

- Overview of HIV/AIDS Bureau (HAB) eligibility determination (ED) requirements for Ryan White (RW) HIV/AIDS Program grantees and providers
  - Part A, B, C, and D grantees and their funded subgrantees (i.e., providers)
- We present best practices in conducting ED, assisting clients to enroll in health insurance, grantee monitoring methods, and quality assessment and performance improvement activities
- Broward County and Palm Beach County Part A program grantees will discuss opportunities and challenges associated with implementing these policies
- We will conclude the workshop by opening the session for your questions and comments

Presentation Overview

- HAB fiscal and universal monitoring requirements for RW Part A and Part B-funded grantees and providers
- Part C and Part D requirements identified in Funding Opportunity Announcements (FOA)
- Practical application of these policies identified through HAB policy studies, technical assistance (TA) to HAB key stakeholders throughout the US, and review of about 4,000 charts
- Unique challenges experienced by RW grantees, providers (i.e., subgrantees), and HIV+ clients
- Resources are offered throughout the presentation

Why Conduct ED?

- Adhere to the RW HIV/AIDS Treatment Extension Act of 2009, HAB monitoring standards, and other federal policies
  - Providers should adhere to their grantee standards and contract requirements
- Ensure clients receive the optimal benefits that they are legally eligible
- Ensure access to health care and medications through enrollment in ADAP, Insurance Continuation Program (ICP), or other public programs
- By enrolling in public and commercial health insurance, clients are ensured access to a full range of health care benefits not covered by the RW Program
  - Benefit from Patient Protection and Affordable Care Act (ACA) and Medicaid expansion
- Ensure income maintenance through disability benefits, Temporary Assistance for Needy Families (TANF), General Assistance (GA), or other programs
- Ensure that HIV clinics and other health care providers are compensated for their services

Parts A and B ED Policies

HAB ED Requirements For Grantees

- **RW legislation, HAB Part A and Part B Universal Monitoring Standards, Frequently Asked Questions (FAQs), and FOAs require**
  - HIV+ individuals be screened within a predetermined period to assess eligibility for RW Program-funded services
  - Following initial screening, clients must be reassessed every six months to determine continued eligibility
- **Grantees must**
  - Establish processes and policies for determining eligibility
  - Monitor receipt and use of health insurance payments by providers as an indication that they are assisting clients to enroll in health insurance
  - Conduct site visits to review client files for appropriate documentation that meets HAB and grantee requirements
  - Train their staff to monitor provider processes
  - Train provider staff in ED assessment and reassessment policies and processes, as well as third party payment sources

HAB ED Requirements For Grantees

- **Eligibility polices that do not deem HIV+ veterans ineligible for RW services due to eligibility for VA benefits**
- **Develop and maintain files that document clients' eligibility including**
  - Proof of compliance with eligibility as defined by the grantee
  - HIV/AIDS diagnosis
  - Low income
  - Uninsured or underinsured status (for which insurance coverage must be verified as proof)
  - Determining eligibility and enrollment in health insurance programs including Medicaid and Medicare
  - For underinsured clients, verification that specific services are not covered by their insurer

HAB ED Requirements for Providers

- Develop and maintain client files documenting clients' eligibility
  - HIV/AIDS diagnosis, low income, verified uninsured or under-insured insurance status, eligibility and enrollment in other third party insurance, ineligibility among underinsured clients, and compliance with eligibility as defined by the grantee
- Document that eligibility, assessment, and reassessment processes takes place within time frames established by the grantee
- Document that all staff involved in ED participate in training
- Provider client data reports are consistent with eligibility requirements specified by the funder and demonstrates eligible clients receive allowable services
- There is no grace period for RW clients that are no longer financial eligible and/or become eligible for Medicaid, Medicare (including Part D), State programs, or commercial insurance
  - The provider is responsible for transitioning ADAP clients if they are not longer financially eligible

HAB ED Requirements for Providers

- Providers must submit monthly and quarterly progress reports to their grantee that identify and address problems in determining eligibility
- A single eligibility record is acceptable for Parts A and B if:
  - Part A, Base B, and ADAP must have the same eligibility criteria that meets the requirements of all titles (including the same percentage of FPL to establish eligibility)
  - There must be an application with supporting documents (e.g., income and insurance verification)
  - The application and supporting documents must be available for review at each of the providers' sties
  - Individual providers must be aware that they are responsible for providing allowable services to eligible clients
  - Sharing of the eligibility application and documents can be done by copying the original application and documents or by electronic access
  - Once a agency determines a client is eligible for RW services, the client can receive any of the agency's services

HAB ED Performance Measures and Methods

- **ED performance measures and methods include documentation of eligibility required in client records, with copies of documents**
  - Proof of HIV status, residence, income eligibility (based on the income limit established by the EMA, TGA, State, ADAP, or ICP)
  - Proof of insurance, no insurance, or underinsurance using approved documentation as required by the EMA, TGA, or the State
  - Eligibility and enrollment forms for other third party payers such as Medicaid and Medicare
  - Document reassessment of clients' eligibility status every six months

Parts C and D ED Policies

Part C ED Requirements

- The RW Program is the payer of last resort, and grantees must ensure that alternate payment sources are pursued
- Grantees and their contractors are expected to pursue vigorously Medicaid enrollment for individuals who are likely eligible for Medicaid coverage, seek Medicaid payment when they provide a covered service for Medicaid beneficiaries, and back-bill Medicaid for RW-funded services provided for all Medicaid eligible patients
- Patients needing medications and are eligible for ADAP or other pharmaceutical programs should be assisted in accessing those resources *before* using Part C Early Intervention Services (EIS) grant funds

Part D ED Requirements

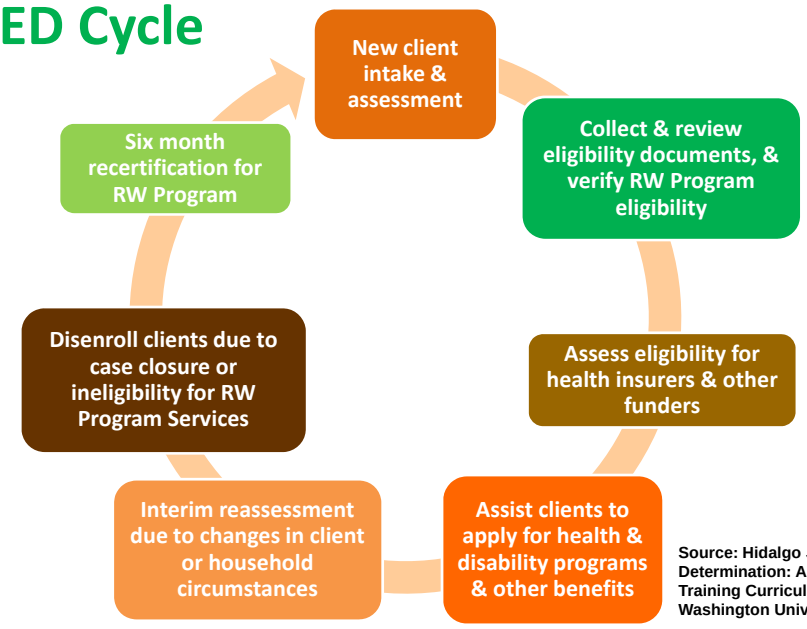
- Eligible individuals: HIV+ women, infants, children, and youth <25 years of age
- RW Program funds are the payer of last resort after billing Medicaid, Children's Health Insurance Program (CHIP), other public/private health insurance, and after billing clients for allowable costs using a sliding fee scale
- RW Program funds cannot be used to supplement payments by Medicaid, Medicare, or other insurance programs
- Ensure that Medicaid billable services are billed to Medicaid
- RW funds cannot be used to supplement payments by Medicaid, Medicare, or other insurance programs

Practical Application of HAB ED Policies

What are you determining?

- Eligibility for the RW-funded programs
  - Identity, HIV+, residence in the service area, household size, household income, Federal Poverty Level (FPL), income ceiling, other criteria set by the grantee
- *Enrollment* in public and/or commercial health insurance programs
- *Eligibility* for public and/or commercial health insurance, as well as public disability programs
  - Based on the client's eligibility, as well as eligibility of family members
- Among insured populations, specific covered services, caps on service utilization, and premiums, co-payments, and deductibles

ED Cycle



Source: Hidalgo J. Eligibility Determination: A National Training Curriculum. George Washington University, 2010.

ED Staffing and Service Delivery Models

Staff commonly conducting ED

- Eligibility workers employed by RW-funded agencies
- Eligibility workers employed by the RW-funded programs
- Medical case managers or non-medical case managers
- ADAP, Local Pharmacy Assistance Program (LPAP), and health insurance premium program staff

Staff contributing information for ED

- Clerical personnel
- Linkage workers or service navigators
- Clinicians (including medical, mental health, and substance abuse treatment)
- Legal services providers

ED model

- Centralized (one agency delegated to conduct ED on behalf of RW-funded providers)
- Semi-centralized (RW-funded medical case management providers conduct ED)
- Decentralized (each RW-funded program conducts ED)

Reading Levels of a Part A Grantee's Forms: An Example

Who Reads the Forms?	Document	Reading Level (US School Grade)
Clients and medical case managers (MCMs)	Appointment Letter	21.2
	Notice of Eligibility	18.5
Clients, MCMs, and supervisors	Assessment Form	7.5
	Consent for Release of Medical Information	13.2
	Intake Form	7.0
	MCM Case Plan	5.2
MCMs and supervisors	Alternative Funding Sources	17.4
	Case Conferencing Form	0
	Case Plan Quarterly Review	0
	Case Supervision Form	0
	Consumer Information Check List	12.8
	Long Term Plan (Discharge Plan)	2.1
	Progress Notes	9.9
MCMs and individuals providing financial support to the client	Statement of Residency	8.0

Household Size Determination

- **Key information to be documented**
  - Who is in the household, what is their relationship to the client, what are their birthdates, what are their sources of income, and the amount of gross income received?
- **Using this example:**
  - *What is the household size?*

Mavis is the Applicant	Relation-ship to Applicant?	Birthdate?	Em-ployed?	Receives Disability or Income Assistance?	Receives Other Income?
Marvin	Husband	2/22/1965	Full Time	No	Yes
Myron	Son	4/28/1992	Full Time	No	No
Mary	Daughter	4/28/1992	No	TANF	No
Michael	Son	4/4/1999	No	SSI	No
Malcolm	Grandson	5/15/2010	No	TANF	Child Support

Income Sources to be Assessed During Intake, Assessment, and Reassessment

- Earned salary or wages through full, part-time, or self-employment
- Social Security Old Age and Survivor Insurance (OASI) Benefits
- Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)
- TANF, GA, or publicly-funded income maintenance programs
- Child or spousal (alimony) support
- Retirement or pension benefits (e.g., veterans, military active duty, and commercial plans)
- Commercial short-term or long-term disability benefits
- Rental income
- Interest, dividends, annuities, royalties, trusts
- Unemployment Benefits
- Worker's Compensation
- In-kind support through free rent, utilities, food, and other basic necessities

Assessing Clients With $0 Income

- How does the grantee define “household” to determine household income?
- How does the client support him/herself without income?
  - How does the client pay for food, clothing, and shelter?
- Is the client unemployed and receiving Unemployment Compensation benefits?
- Is the client unable to work due to disability? Does the client receive disability benefits?
- Does the client reside with his/her minor children? Is the client pregnant?
  - Does the client receive TANF cash benefits?
- Does the client receive GA or other income maintenance program income benefits?
- Does the client receive Supplemental Nutrition Assistance Program (SNAP) benefits?
  - *SNAP benefits are NOT income*

Annual Household Income Determination

Mavis' Family Income	Relationship to Applicant?	Earned Wages or Salary	Disability or Income Assistance	Other Income?	Total Gross Monthly Household Income
Mavis	Applicant	$0	$698	$0	
Marvin	Husband	$3,000	No	$1,500	
Myron	Son	$2,000	No	$0	
Mary	Daughter	$0	$400	$0	
Michael	Son	$0	$698	$0	
Malcolm	Grandson	$0	$354	$115	
Total Income		$5,000	$2,150	$1,615	$8,765

Monthly Gross Income = $8,765 **Annual Gross Income= $105,180**

Determining Income Eligibility For Mavis' Family

Persons in Family/ Household	DHHS 2012 Poverty Guidelines	FPL Upper Limit
		300% FPL
1	$11,170	$33,510
2	$15,130	$45,390
3	$19,090	$57,270
4	$23,050	$69,150
5	$27,010	$81,030
6	$30,970	$92,910
7	$34,930	$104,790
8	$38,890	$116,670

Source: Federal Register: http://www.gpo.gov/fdsys/pkg/FR-2012-01-26/pdf/2012-1603.pdf

Common Errors Found in Intake and Assessment

- **Identity:** missing photo ID, illegible photo
- **Residency:** missing documentation showing residency in EMA
- **HIV+ status:** no document confirming HIV seropositivity, CD4 count
- **Household size:** individuals meeting State, EMA, or TGA household definition are not identified during assessment
- **Household income:** applicants' income poorly documented, family members' income not assessed, clients claiming $0 income not probed for how they are able to live with no income, clients reporting $0 income documented in other records as being employed, undercounting income from self-employment, and missed income from sources other than wages

Assessing Health Insurance Enrollment at Intake

- Check paystubs *carefully*
- Ask the applicant directly if he/she or his/her spouse is insured
- Ask the applicant if he/she can enroll in insurance through his/ her employer
  - If the applicant reports that he/she declined available health insurance, find out why and help to address concerns (e.g., cost or disclosure)
- If the applicant reports his/her employer does not offer insurance, check the employer's HR website and/or ask for an employer letter
- If the applicant is < 26 years of age, ask if his/her parents are insured and inquire if he/she can enroll in parents' insurance
- If the applicant is a university or college student, check the school's website, and counsel the client to enroll in available insurance
- Query the MA electronic verification system and subscribe to commercial web-based query systems to identify current Medicare and commercial insurance enrollment
  - Avality, Capario, Medifax POS, Passport Health Communications, WebMD Envoy

Navigating the Health Care Insurance Market Is Complex and Likely to Become More Challenging

- HIV+ individuals in many States and DC currently have relatively ample health care insurance options compared to other jurisdictions
- Applicants for RW Program services may be enrolled in or eligible for an array of health insurance options and assistance to pay for premiums, co-payments, and deductibles
  - Commercial or publicly funded managed care plans
  - Assistance in paying for insurance through COBRA benefits
- With an abundance of options comes the burden on HIV+ clients to understand their options and select the best benefits and coverage within their financial resources and other constraints (e.g., employer benefits, ability to pay co-payments)
- Portability of insurance is unavailable for some health plans
- HIV+ clients may be confused about the options available to them, and may need to rely on case managers or other HIV program staff to assist them to select and retain coverage
- Implementation of the ACA contributes to that confusion

Public Health Insurance Programs: Pennsylvania Example

- **Currently, public and commercial health insurance options for HIV+ individuals vary considerably among States, DC, and territories**
- **Options expand considerably with ACA implementation in most states**

Client Characteristics	Publicly Funded Insurer or Payer
Low-income children and adolescents 18 years of age or younger	PA Medicaid Program
Low-income aged, blind, disabled adults, and Qualified Medicare Beneficiaries	PA Medicaid Program
Children with special health care needs	PA Special Kids Network
Developmentally delayed children and adults	PA Office of Developmental Programs, several Medicaid waiver programs
Uninsured, low-income children	PA Children's Health Insurance Program (CHIP)
Uninsured disabled individuals	Pre-Existing Insurance Program (PCIP), PA Fair Care
Active duty and retired military, and dependents	TRICARE
Individuals receiving hemodialysis or requiring a kidney transplant	Medicare End Stage Renal Disease (ESRD) Program
Children or adults with long term disabilities	Medicare
Adults 65 years of age or older	Medicare
Chronically disabled individuals	PA AIDS and Other Support Services Waivers
Veterans of the US military services	Veterans Administration

Commercial Insurance

- **Coverage is commonly through group benefits via employers or association membership**
  - Individual coverage can be purchased through carriers
  - Assess coverage through spousal benefits, domestic partner benefits, or parental benefits for youth > 26 years of age
  - COBRA benefits may also be available
- **Benefits vary substantially among carriers**
- **ED must address**
  - Waiting periods for pre-existing medical conditions
  - Annual or lifetime expenditure caps
  - Service utilization limits for specific services (e.g., number of prescriptions, home health visits)
  - HIV+ beneficiaries of these plans may receive RW Program benefits during waiting periods or while service caps are exceeded

Pre-Existing Condition Insurance Program (PCIP)

- National program authorized by the ACA
- Covers a broad range of health benefits, including primary and specialty care, hospital care, and prescription drugs, with no waiting period
- Eligible applicants must be a US citizen or reside in the US legally, been without health coverage for at least the last six months, have a pre-existing condition, or been denied coverage due to a health condition
- Enrollees can choose from three plan options
  - Different levels of premiums, calendar year deductibles, prescription deductibles, and prescription copays
  - Each plan option provides preventive care (paid at 100%, with no deductible) when a beneficiary sees an in-network doctor, including annual physicals
  - For other care, participants pay a deductible before PCIP pays for their health care and prescriptions
- After the participant pays the deductible, beneficiary pays 20% of medical costs in-network
  - Maximum out-of-pocket payment for covered services in a CY is $5,950 in-network/$7,000 out-of-network
  - No lifetime maximum or cap on the amount paid
- Monthly premiums and other information can be found at: https://www.pcip.gov/StatePlans.html#StateInformation

HAB's Policy Regarding HIV+ Veterans

- HAB clarified their policy in 2004 about providing RW Program-funded services to HIV+ veterans who also are eligible for VA benefits: http://hab.hrsa.gov/law/0401.htm
- RW Program-funded providers
  - Should inquire if an HIV+ client is a veteran and enrolled in the VA
  - May not deny services, including medication, to veterans who are otherwise eligible for the RW Program
  - Should be knowledgeable about VA medical benefits, including medications
  - Must coordinate health care benefits for veterans
  - Make HIV+ veterans aware of VA services available, procedures for getting VA care, and help them to navigate HIV care
- HAB policy states that even if a veteran is enrolled in the VA, he/she does not have to use the VA as their exclusive health care provider
- Eligibility information is available at: http://www.va.gov/healtheligibility/HECHome.htm
- Eligibility for most veterans health care benefits is based on active military service in the Army, Navy, Air Force, Marines, or Coast Guard, and other criteria

Role of RW Grantees in ED

ED Best Practices for RW Grantees

- Align Part A and B standards to the extent possible
- Ensure grantees and their staff are familiar with the HAB ED standards and related policies, as well as State and local health insurance systems, and federal disability programs
- Ensure adherence to HAB policies among staff conducting ED and their supervisors (e.g., ADAP, LPAP, and health continuation programs) and conduct internal audits
- Clearly identify expectations to funded RW-funded providers through RFAs, ED standards and performance measures, training, and quality improvement
  - Assist RW-funded providers to develop and refine policies and procedures and undertake training and quality performance
- Use standardized forms and train personnel in their use
  - Ensure forms are linguistically appropriate to the populations served
- Require at least one full month of paystubs for employed clients and their spouses and/or a copy of the annual SSA award for SSI, SSDI, and OASI beneficiaries

Assisting Clients to Enroll in Health Insurance

- **May a RW client refuse to enroll in health insurance?**
  - No. It is important to assist clients to address concerns about discrimination and the cost of health insurance premiums, co-payments, and deductibles.
- **It is important to assist clients to weigh their health insurance options and select the plan that best meets their clinical, geographic, and financial needs**
  - It is important to help Medicaid beneficiaries avoid managed care plan auto-assignment
- **It is critical that well-trained, experienced staff be readily available to assist clients**
  - Few grantees and RW providers employ such staff
  - May be a resource that may be supported with Part B funds
- **Implementation of the ACA and Medicaid expansion make funding such staff imperative**

Other ED Best Practices for RW Grantees

- Centralize ED processes, using an out-stationed model, to reduce redundancy, improve accuracy, and reduce client burden
  - It is important, however, that the ED system is highly accurate and timely
- Modify client-level data systems to allow ED documents to be viewed by other RW providers, and query routinely with public and commercial insurance e-verification systems
- Routinely monitor your state's ACA implementation and changes in public entitlement and discretionary programs that impact eligibility
  - Changes to major payers in your community should be rapidly communicated to funded providers, including ED workers
  - Meet with State or county Medicaid staff to become familiar with their processes, subscribe to provider announcement lists, and ask if your staff can participate in training
  - Advise Medicaid or other State health financing staff in designing ACA demonstration projects, enhanced reimbursement systems, and managed care contracting specifications

Other ED Best Practices for RW Grantees

- Establish processes with SSA to fast track applications and to train State disability determination staff about HIV disease
- Collaborate with other public systems to identify resources and coordinate referrals
  - Other systems include substance abuse and mental health treatment, affordable housing, pantry/nutrition programs, transportation, etc.
- Fund legal services to pursue administrative procedures following rejected disability or other claims and to assist clients in employment discrimination cases
- Use client-level data reported by RW-funded providers to identify providers with high rates of missing or unknown data for household size, household income, FPL, and insurance status
  - Undertake data quality improvement projects (QIPs) through internal or external audits
  - Provide or arrange for TA for core service providers with high rates of uninsured clients to prepare for the ACA and other Medicaid expansion efforts

ED Standards, Performance Measurement, and Monitoring Determination Activities

External and External ED Monitoring Best Practices

- Develop standardized ED monitoring tools. monitoring instructions, and training curriculum
  - Define clear goals for monitoring such as provider adherence to HAB and grantee standards
  - Incorporate ED assessment in clinical chart review to identify clients that would benefit from assistance in applying for SSA disability benefits
- Design statistically accurate samples for chart review
- Read key sections of the client's medical case management and medical chart
  - Do not just focus only on the medical case management chart
  - Review the intake, medical and case management progress notes, clinical consultation reports, inpatient discharge summaries, and correspondence sections of the health record
- Require ED supervisors to conduct routine internal monitoring, including quarterly chart reviews
  - Develop ED standards that require routine internal monitoring
- Pre-print key data variables for monitors to compare with information in the chart

Other External and External ED Monitoring Best Practices

- Recompute monthly income to verify income
- Check paystubs for "medical, dental, and vision" deductions
- Look for copies of health insurance cards
- Use client-level data to identify "logical errors" in health insurance
  - Uninsured children and youth < 18 years of age
  - Adults 65 years of age or older
  - Single adults reporting monthly income of $694
  - Pregnant women
  - Clients with chronic conditions (e.g., bipolar, schizophrenia, ESRD) or indications of long-standing AIDS diagnosis
- Clinical progress notes and consultation reports often provide information regarding employment and health insurance coverage

Resources for Assessing Health Insurance, Income Assistance, and Eligibility or Other Resources

Ryan White HIV/AIDS Program Eligibility Determination Assessment Form

1. Agency 2. Med Rec # 3. Reviewer 4. URN

Patient Health and Disability Insurance Enrollment

Health Insurer	Account #	Start Date	End Date	Coverage?	Describe Evidence of Insurance in Chart
1. Medicaid				Full? Managed Care? Share of Cost? Medically Needy? QMB? Part A? Part B? Part D?	
2. Medicare					
3. Commercial Name?					
4. VA					
5. Other Insurers Name?					

10. Was the client's health insurance benefits terminated or suspended? Yes No
11. If YES, describe termination or suspension (include all termination or suspension codes and dates).

Disability and Survivor Benefits	Account #	Award Date	Describe Evidence of Benefits in the Chart
12. SSA Old Age (≥ 65 Years)			
13. SSA SSI			
14. SSA SSDI			
15. Survivor Benefits (Widow, Widower, Child)			
16. Commercial Disability Insurer Name?			

17. Was the client's SSA disability or old age benefits terminated or suspended? Yes No
18. If YES, describe information regarding termination or suspension (include all termination or suspension codes and dates:
19. Was the client enrolled in Temporary Assistance to Needy Families (TANF) during the review period? Yes No
20. Did the client's physician(s) comment in the progress notes that the client has (had) health insurance? Yes No

Date	Location in Chart	Comment

21. Did the client's medical case manager(s) report in the chart that the client has (had) health insurance? Yes No

Date	Location in Chart	Comment

22. Do the clinic's third party insurance queries state that the client has health insurance? Yes No NA

Date	Location in Chart	Comment

23. Was the client employed in the review period? Yes No Unk
24. If YES, were pay stubs in the client's chart? Yes No
25. If YES, did pay stubs document deductions for, or employer contributions to, health insurance? Yes No
26. If the client was EMPLOYED and no insurance coverage is noted in the health record, was there a letter from the employer reporting that health insurance is NOT offered? Yes No NA

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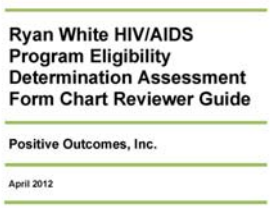

Ryan White HIV/AIDS Program Eligibility Determination Assessment Form Chart Reviewer Guide

Positive Outcomes, Inc.

April 2012

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ED Quality Assessment and Improvement: Design Used to Assess ED Activities Funded Five Part A Grantees

Key Facts	Grantee 1	Grantee 2	Grantee 3	Grantee 4	Grantee 5
Region	Southwest	Northeast	South	South	South
Service Area	Large urban, and adjoining rural areas	Suburban, and adjoining rural counties	Moderate urban, and adjoining rural counties	Large urban	Large urban, and adjoining rural areas
Providers	1 hospital-based HIV clinic, 2 FQHCs, 1 CHC	2 ASO, 2 hospital-based HIV clinic2, 1 FQHC, 1 county health dept	3 ASOs (1 co-located in HIV clinic), 1 county health dept	Centralized Part A ED Unit	3 ASOs, 2 community ID practices, 1 county health dept
Assessment Design	Chart review	Chart review	Chart review	Electronic records	Chart review
Chart Review Tool	Tool measures attainment of HAB and grantee monitoring standards, and assesses key components of RW Program and third party insurance eligibility				
# Charts Reviewed	285	407	325	144	493

Findings of ED Quality Assessments Among Providers Funded by Five Part A Grantees

Average Error Rate	Grantee 1	Grantee 2	Grantee 3	Grantee 4	Grantee 5
Region	Southwest	Northeast	South	South	South
Average Household Size	Not Assessed	**38%**	**58%**	Not Assessed	Not Assessed
Household Income	Not Assessed	**74%**	**77%**	**35%**	Not Assessed
Health Insurance	**32%**	**39%**	**27%**	**11%**	**44%**

Grantee Strategies for Improving RW HIV/AIDS Program ED Activities

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Questions And Discussion